CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Healthcare Facilities Management

(New Administrative Regulation)

907 KAR 3:225. Specialty intermediate care (IC) clinic service and coverage policies and requirements.

RELATES TO: KRS 205.520(3)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), and 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes Medicaid program service and coverage policies and requirements regarding specialty intermediate care clinic services.

Section 1. Definitions. (1) “1915(c) home and community based services waiver program” means a Kentucky Medicaid program established pursuant to and in accordance with 42 U.S.C. 1396n(c).

(2) “Audiologist” is defined by KRS 334A.020(5).

(3) “Behavior Analyst Certification Board” means the nonprofit corporation:

(a) Established in 1998; and

(b) Known as the Behavior Analyst Certification Board®, Inc.

(4) “Board Certified Behavior Analyst” means an individual who is currently certified by the Behavior Analysis Certification Board as a certified behavior analyst.

(5) “Clinical laboratory” means a medical laboratory pursuant to KRS 333.020(3).

(6) “Department” means the Department for Medicaid Services or its designee.

(7) “Developmental disability” means a severe chronic disability which:

(a) Is attributable to a mental or physical impairment or combination of mental and physical impairments manifested before the person attains the age of twenty-two (22);

(b) Is likely to continue indefinitely;

(c) Results in substantial limitations in three (3) or more areas of major life activity including:

1. Self-care;

2. Receptive and expressive language;

3. Learning,

4. Self direction;

5. Mobility; and

6. Capacity for independent living and economic sufficiency; and

(d) Requires individually planned and coordinated services of a lifelong or extended duration.

(8) “Enrollee” means an individual who is enrolled with a managed care organization for the purposes of receiving Medicaid program or KCHIP program covered services.

(9) “Epileptologist” means a physician who specializes in treating patients who have

epilepsy.

(10) “Federal financial participation” is defined in 42 CFR 400.203.

(11) “Functional assessment” means an assessment performed using evidenced-based tools, direct observation, and empirical measurement to obtain and identify functional relations between behavioral and environmental factors.

(12) “Licensed psychologist” means an individual who is currently licensed in accordance with KRS 319.050.

(13) “Licensed psychological practitioner” means an individual who is currently licensed in accordance with KRS 319.053.

(14) “Licensed psychological associate” means an individual who is currently licensed in accordance with KRS 319.064.

(15) “Managed care organization” or “MCO” means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 CFR 438.2.

(16) “Medically necessary” means determined by the department to be needed in accordance with 907 KAR 3:130.

(17) “Neurologist” means a physician who specializes in neurology.

(18) “Occupational therapist” is defined by KRS 319A.010(3).

(19) “Occupational therapist assistant” is defined by KRS 319A.010(4).

(20) “Ophthalmic dispensing” is defined by KRS 326.010(2).

(21) “Ophthalmic dispenser” means an individual licensed to perform ophthalmic dispensing in accordance with KRS 326.030.

(22) “Physical therapist” is defined by KRS 327.010(2).

(23) “Physical therapist assistant” means a skilled health care worker who:

(a) Is certified by the Kentucky Board of Physical Therapy; and

(b) Performs physical therapy and related duties as assigned by the supervising physical therapist.

(24) “Physical therapy” is defined by KRS 327.010(1).

(25) “Physician” is defined by KRS 311.550(12).

(26) “Physician services” means the practice of medicine or osteopathy provided by a physician.

(27) “Positive behavior support specialist” means an individual who:

(a) Provides:

1. Evidence-based individual interventions that assist a recipient with acquiring or maintaining skills for community living; and

2. Behavioral intervention to reduce maladaptive behaviors;

(b) Has a master’s degree in a behavioral science and one (1) year of experience in behavioral programming; and

(c) Has at least one (1) year of direct services with individuals with an intellectual or developmental disability.

(28) “Practice of medicine or osteopathy” is defined by KRS 311.550(11).

(29) “Practice of psychology” is defined by KRS 319.010(6).

(30) “Primary care provider” means:

(a) A licensed primary care physician who is a:

1. Doctor of medicine or osteopathy; and

2. General practitioner, family practitioner, pediatrician, internist, obstetrician, or gynecologist;

(b) A licensed, certified advanced practice registered nurse who:

1. Has a "Collaborative Practice Agreement for Prescriptive Authority" in accordance with KRS 314.042; and

2. Has a signed written agreement with a primary care physician for backup twenty-four (24) hours per day seven (7) days a week for needed prescriptions and other primary care services outside the scope of practice of the advanced practice registered nurse;

(c) A physician group practice which bills the department using a group practice Medicaid provider number;

(d) A licensed primary care center operating under physician supervision which has at least one (1) full-time equivalent primary care physician who is a general practitioner, family practitioner, doctor of osteopathy, pediatrician, internist, obstetrician, or gynecologist;

(e) A licensed rural health clinic operating under physician supervision by a primary care physician who is a general practitioner, family practitioner, doctor of osteopathy, pediatrician, internist, obstetrician, or gynecologist; or

(f) A licensed physician specialist who is a doctor of medicine or osteopathy if the specialist agrees to serve as a primary care provider.

(31) “Psychiatrist” is defined by KRS 504.060(8).

(32) “Psychological services” means the practice of psychology.

(33) “Psychotropic medication” means a medication that is:

(a) Prescribed to treat the symptoms of a psychiatric disorder; or

(b) Utilized emergently to address psychiatric symptoms.

(34) “Recipient” is defined by KRS 205.8451(9).

(35) “Specialty intermediate care clinic” or “specialty IC clinic” means a clinic licensed pursuant to 902 KAR 20:410.

(36) “Speech-language pathologist” is defined by KRS 334A.020(3).

(37) "Rural health clinic" is defined by 42 C.F.R. 405.2401(b).

Section 2. Conditions of Participation. A specialty intermediate care clinic service shall be provided by an individual:

(1) Employed by a specialty intermediate care clinic; or

(2) Working for a specialty intermediate care clinic via a contractual agreement.

Section 3. Eligible Population. (1) To be eligible to receive specialty IC clinic services, an individual shall:

(a) Be a recipient:

(b) Have a mental illness, intellectual disability, or developmental disability; and

(c) Meet the patient status criteria established in:

1. Section 4(4) of 907 KAR 1:022; or

2. Section 4(5) of 907 KAR 1:022.

(2)(a) A recipient shall be eligible to receive services stated in Section 6 of this administrative regulation and in accordance with the requirements established in Section 6 of this administrative regulation if the recipient is:

1. Eligible in accordance with subsection (1) of this section;

2. Not receiving services via:

a. A 1915(c) home and community services waiver program; or

b. An intermediate care facility for individuals with an intellectual disability; and

3. Enrolled with a managed care organization.

(b) A recipient shall be eligible to receive services stated in Section 5 of this administrative regulation and in accordance with the requirements established in Section 5 of this administrative regulation if the recipient is:

1. Eligible in accordance with subsection (1) of this section;

2. Receiving services via:

a. A 1915(c) home and community services waiver program; or

b. An intermediate care facility for individuals with an intellectual disability; and

3. Not enrolled with a managed care organization.

Section 4. General Requirements Regarding Services. (1)(a) The department shall:

1. Reimburse for a specialty IC clinic service if the service was:

a. Medically necessary; and

b. Provided:

(i) By a specialty IC clinic; and

(ii) To an individual who is eligible to receive specialty IC clinic services pursuant to Section 3(1) and (2)(b) of this administrative regulation; or

2. Not reimburse for a specialty intermediate care clinic service if the service does not:

a. Meet the criteria established in paragraph (a) of this subsection; or

b. Comply with subsection (2) of this section.

(b) A managed care organization shall:

1. Reimburse for a specialty IC clinic service if the service was:

a. Medically necessary; and

b. Provided:

(i) By a specialty IC clinic; and

(ii) To an individual who is eligible to receive specialty IC clinic services pursuant to Section 3(1) and (2)(a) of this administrative regulation; or

2. Not reimburse for a specialty intermediate care clinic service if the service does not:

a. Meet the criteria established in paragraph (a) of this subsection; or

b. Comply with subsection (2) of this section.

(2) Services provided at a specialty IC clinic shall comply with the requirements established in 42 CFR 440.90.

Section 5. Specialty Intermediate Care Clinic Services for Recipients Who are Not Enrolled with a Managed Care Organization. The following shall be the covered specialty intermediate care clinic services for an individual who is not enrolled with a managed care organization and who is eligible in accordance with Section 3(1) and (2)(b) of this administrative regulation:

(1) Dental services provided:

(a) By an authorized practitioner in accordance with 907 1:026; and

(b) In accordance with the limits established in 907 KAR 1:026;

(2) Psychiatric services provided:

(a) By a:

1. Psychiatrist; or

2. Physician; and

(b) In accordance with the psychiatric service limit established in 907 KAR 3:005;

(3) Psychological services provided by a licensed psychologist, licensed psychological practitioner, licensed psychological associate;

(4) Psychotropic medication management provided by an advanced practice registered nurse, physician, or psychiatrist;

(5) Neurology services provided by a neurologist;

(6) Epileptology services provided by an epileptologist;

(7) Preventive health care;

(8) Primary and sub-specialist medical assessment and treatment;

(9) Occupational therapy provided:

(a) By an occupational therapist or occupational therapist assistant; and

(b) In accordance with the limits and requirements established in Section 6 of this administrative regulation;

(10) Physical therapy provided:

(a) By a physical therapist or physical therapist assistant; and

(b) In accordance with the limits and requirements established in Section 6 of this administrative regulation;

(11) Speech therapy provided:

(a) By a speech-language pathologist; and

(b) In accordance with the limits and requirements established in Section 6 of this administrative regulation;

(12) Nutritional or dietary consultation;

(13) Mobility evaluation or treatment;

(14) Positive behavioral support services which shall:

(a) Be the systematic application of techniques and methods to influence or change a behavior in a desired way;

(b) Be provided to assist a recipient to learn a new behavior that is directly related to existing challenging behaviors or a functionally equivalent replacement behavior for identified challenging behaviors;

(c) Include a functional assessment of the recipient's behavior which shall include:

1. An analysis of the potential communicative intent of the behavior;

2. The history of reinforcement for the behavior;

3. The critical variables that preceded the behavior;

4. The effects of different situations on the behavior;

5. A hypothesis regarding the motivation, purpose, and factors which maintain the behavior;

(d) Include the development of a positive behavioral support plan which shall:

1. Be developed by a behavioral support specialist:

2. Be implemented by staff in all relevant environments and activities;

3. Be revised as necessary at least once every six (6) months;

4. Define the techniques and procedures used;

5. Be designed to equip the recipient to communicate his or her needs and to participate in age-appropriate activities;

6. Include the hierarchy of behavior interventions ranging from the least to the most restrictive;

7. Reflect the use of positive behavioral approaches; and

8. Prohibit the use of prone or supine restraint, corporal punishment, seclusion, verbal abuse, or any procedure which denies private communication, requisite sleep, shelter, bedding, food, drink, or use of a bathroom facility;

(e) Include the provision of competency-based training to other providers concerning implementation of the positive behavioral support plan;

(f) Include the monitoring of a recipient's progress which shall be accomplished through:

1. The analysis of data concerning the frequency, intensity, and duration of behavior; and

2. The reports of a provider involved in implementing the positive behavioral support plan;

(g) Provide for the design, implementation, and evaluation of systematic environmental modifications;

(h) Be provided by a behavioral support specialist; and

(i) Be documented by a detailed staff note which shall include:

1. The date of the service;

2. The beginning and end time;

3. The signature, date of signature, and title of the behavior support specialist;

(15) Audiology provided by an audiologist and in accordance with the following:

(a) The limits established in 907 KAR 1:038 for services provided to an individual under the age of twenty-one (21) years shall be the limits for audiology services provided in a specialty intermediate care clinic regardless of the recipient's age; and

(b) The restriction established in 907 KAR 1:038 of not covering audiology services for an individual who is at least twenty-one (21) years of age shall not apply to audiology services provided in a specialty intermediate care clinic;

(16) Ophthalmic dispensing provided by an ophthalmic dispenser;

(17) A prescribed drug covered in accordance with 907 KAR 1:019;

(18) Medication consultation;

(19) Medication management;

(20) Seizure management;

(21) Diagnostic services;

(22) Clinical laboratory services;

(23) Physician services in accordance with the limits and requirements established in 907 KAR 3:005; or

(24) Laboratory services in accordance with the limits and requirements established in 907 KAR 1:028.

Section 6. Specialty Intermediate Care Clinic Services for Recipients Who are Enrolled with a Managed Care Organization. The following shall be the covered specialty intermediate care clinic services for an individual who is enrolled with a managed care organization and who is eligible in accordance with Section 3(1) and (2)(a) of this administrative regulation:

(1) Dental services provided in accordance with 907 KAR 1:026 except that a dentist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(2) Physicians services provided in accordance with 907 KAR 3:005 except that:

(a) A physician who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(3) Psychiatric services provided in accordance with 907 KAR 3:005 except that:

(a) A psychiatrist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(b) A physician who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(c) An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(4) Behavioral health services in accordance with:

(a) 907 KAR 1:054 except that:

1. A clinical psychologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

2. An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(b) 907 KAR 1:082 except that:

1. A clinical psychologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

2. An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(c) 907 KAR 1:044 except:

1. That:

a. A clinical psychologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

b. A psychiatrist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

c. An advanced practice registered nurse who is certified in the practice of mental health nursing, meets the requirements of 201 KAR 20:057, and who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; and

2. For the following which shall not be covered if provided by a specialty IC clinic:

a. Inpatient services;

b. Therapeutic rehabilitation services for adults;

c. Therapeutic rehabilitation services for children; or

d. Services in a detoxification setting;

(5) Audiology services provided in accordance with 907 KAR 1:038 except that an audiologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(6) Ophthalmic dispensing provided by an ophthalmic dispenser in accordance with 907 KAR 1:038 except that an ophthalmologist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(7) A prescribed drug covered in accordance with 907 KAR 1:019 except that a pharmacist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(8) Preventive health care in accordance with 907 KAR 3:005 except that:

(a) A physician who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services;

(9) Occupational therapy in accordance with 907 KAR 3:005 except that an:

(a) Occupational therapist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) Occupational therapy assistant who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(10) Physical therapy in accordance with 907 KAR 3:005 except that a:

(a) Physical therapist who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) Physical therapist assistant who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(11) Speech therapy in accordance with 907 KAR 3:005 except that a speech language pathologist who is an employee of or under contract with a specialty IC clinic shall be authorized to provide the services;

(12) Diagnostic services in accordance with 907 KAR 1:014, 907 KAR 1:054, 907 KAR 1:082, or 907 KAR 3:005 except that:

(a) A physician who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(b) An advanced practice registered nurse who is employed by or under contract with a specialty IC clinic shall be authorized to provide the services; or

(13) Laboratory services in accordance with 907 KAR 1:028 except that if a specialty IC clinic's laboratory does not meet the requirements of 907 KAR 1:028, the specialty IC clinic shall be authorized to provide the services via a contractual relationship with a laboratory which meets the requirements of 907 KAR 1:028.

Section 7. Therapy Limits. (1)(a) To be reimbursable by the department, occupational therapy, physical therapy, or speech therapy shall be limited to thirty (30) visits per twelve (12) months for a recipient except as established in paragraph (b) of this subsection.

(b) The therapy limits established in paragraph (a) of this subsection shall:

1. Not apply to a recipient under twenty-one (21) years of age; and

2. Be over ridden by the department if the department determines that an additional visit or visits beyond the limit are medically necessary.

Section 8. No Duplication of Service. (1) The department shall reimburse no more than one (1) provider for the provision of a given service to a recipient on a given day.

(2) There shall be no duplicate billing to the department regarding a given service provided to a recipient on a given day.

Section 9. Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies federal financial participation for the policy; or

(2) Disapproves the policy.

Section 10. Appeal Rights. (1) An appeal of a department decision regarding a Medicaid recipient based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563.

(2) An appeal of a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:671.

907 KAR 3:225

REVIEWED:

Date

_____
Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

Date

_____
Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

907 KAR 3:225

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on June 21, 2013, at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing June 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 3:225
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This is a new administrative regulation which establishes Medicaid specialty intermediate care (IC) clinic service and coverage policies and requirements.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid policies and requirements for specialty IC clinic services related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate-care facilities for individuals with an intellectual disability (ICF-IID) as a means of serving individuals in the most integrated setting appropriate to their needs.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid policies and requirements for specialty IC clinic services.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the statutes by establishing Medicaid policies and requirements for specialty IC clinic services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Affected individuals include Medicaid recipients currently residing in an intermediate care facility for individuals with an intellectual disability but who may be able to transition to a

community setting as a result of this administrative regulation; individuals who are participating in a 1915(c) home and community based waiver program; and individuals who are neither of the aforementioned two (2) populations but are enrolled with a managed care organization. Additionally, the clinics themselves will be affected. One (1) facility – located in Louisville, has already been constructed and the start of construction for another facility – in Somerset, KY – is anticipated to begin in June 2013.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: If a given specialty IC clinic wishes to be reimbursed by Medicaid for services provided to Medicaid recipients, the clinic will have to comply with the service requirements, practitioner requirements (including practitioner qualifications), and be licensed as a specialty IC clinic.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost other than administrative cost associated with compliance is imposed on the regulated entities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients currently residing in an intermediate care facility for individuals with an intellectual disability; are receiving services via a 1915(c) home and community based waiver program; or are neither of the two (2) aforementioned but are enrolled with a managed care organization would benefit by being able to receive these outpatient clinic services.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services estimates that implementing this administrative regulation will cost DMS $600,000 per month (state and federal combined) for each month of implementation in state fiscal year 2013.

(b) On a continuing basis: DMS projects that implementing the administrative regulation will cost approximately $7.2 million (state and federal combined) annually.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds from state general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is not applied as the regulated entities are regulated uniformly by this administrative regulation.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 3:225
Agency Contact Person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services (DMS) and the Department for Behavioral Health, Developmental and Intellectual Disabilities will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS projects no revenue will be generated by the administrative regulation.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS projects no revenue will be generated by the administrative regulation.
   (c) How much will it cost to administer this program for the first year? DMS estimates that implementing this administrative regulation will cost DMS $600,000 per month (state and federal combined) for each month of implementation in state fiscal year 2013.
   (d) How much will it cost to administer this program for subsequent years? DMS projects that implementing the administrative regulation will cost approximately $7.2 million (state and federal combined) annually.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 3:225
Agency Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. The mandate source is a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate-care facilities for individuals with an intellectual disability as a means of serving individuals in the most integrated setting appropriate to their needs.

2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate-care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.